

THE DIVISION OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

FILED NOV 8 1957

State File No. **37811**  
Registrar's No. **10256**

BIRTH NO. _____		REG. DIST. NO. <b>318</b>		PRIMARY REG. DIST. NO. <b>1003</b>	
1. PLACE OF DEATH a. COUNTY _____			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE <b>Illinois</b> b. COUNTY <b>St. Clair</b>		
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN <b>St. Louis</b>		c. LENGTH OF STAY (In this place) <b>10 days</b>		c. CITY OR TOWN <b>Madison</b> d. Is Residence within limits of a city or incorporated town? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
d. FULL NAME OF HOSPITAL OR INSTITUTION <b>Peoples Hospital</b>			e. STREET ADDRESS (If rural, give location) <b>Eagle Park Acres</b>		
3. NAME OF DECEASED (Type or Print) <b>JOHN</b>			a. (First) _____ b. (Middle) _____ c. (Last) <b>MCNEACE</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Oct. 25, 1957</b>
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) <b>Married</b>		8. DATE OF BIRTH <b>Jan. 20, 1892</b>	9. AGE (In years last birthday) <b>65</b> If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 WKS.: Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Terminal R.R.</b>		11. BIRTHPLACE (City and State or Foreign Country) <b>Eudora, Mississippi</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13a. FATHER'S NAME <b>James McNease</b> 13b. MOTHER'S MAIDEN NAME <b>Lizzie McDonald</b> 14. NAME OF HUSBAND OR WIFE <b>Ruby McNease</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT'S SIGNATURE OR NAME <b>Ruby McNease</b> ADDRESS <b>Eagle Park Acres, Madison, Illinois</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)  *This does not mean the mode of dying, such as heart failure, asthma, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) <b>Cerebral Hemorrhage</b> INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>331K</b>			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? <b>2</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) _____	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____	
22. I hereby certify that I attended the deceased from <b>Oct 10</b> , 19 <b>57</b> , to <b>Oct 25</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>Oct 25</b> , 19 <b>57</b> , and that death occurred at <b>3:30 P.M.</b> , from the causes and on the date stated above.					
23. SIGNATURE <b>John McNease</b> (Degree or title) _____		23b. ADDRESS <b>501 W. 1st &amp; 7th St. St. Louis, Mo.</b>		23c. DATE SIGNED <b>Oct 30, 1957</b>	
24a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		24b. DATE <b>10/28/57</b>		24c. NAME OF CEMETERY OR CREMATORY <b>Booker Washington</b>	
24d. LOCATION (City, town, or county) (State) <b>Centreville Township, Ill.</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Earl Smith</b> ADDRESS <b>2114 Mo. Ave. St. Louis, Ill.</b> (Licensed Embalmer's Statement on Reverse Side)			

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Student Embalmer No. .... working under my personal supervision..

Student .....  
Signature of Student Embalmer

Signed *Ben H. Baldwin*

Licensed Embalmer No. *2420*

P. O. Address *721 N. 26th*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.